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ABSTRACT

A humanistically-oriented dynamic approach for the treatment of depression in older persons is presented. A multi-level therapeutic model of treatment is discussed in detail. Included are initiation of the therapeutic relationship, specific tools for problem-solving, relationship building, and insight, termination, transference, and countertransference issues. (Author)

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DYNAMIC TREATMENT OF THE AGED

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Freud believed elderly persons to be poor candidates for individual psychotherapy because of their "limited aged ego and intellect" (Freud, 1924 A); their lack of motivation to endure the tensions mobilized by therapy (Freud, 1924 A); and, the indefinite time prolongment of therapy due to the large mass of material that needed to be dealt with, successful outcome was to be a possibility (Freud, 1924 B). In 1919, Abraham (1949) became skeptical of Freud's notions and brought to light the idea that the age of the neurosis was much more important than the age of the patient.

Physical limitations, multiple losses, the great number of experiences encountered during the life span, and age difference between therapist and patient are just some of the many variables which make the elderly client unique, and which must be addressed in treatment techniques. Different strategies have been reported in the literature (Alexander and French, 1946; Butler, 1960; and Safirstein, 1972). These dynamically-oriented approaches differ not only from formalized analysis, but from many of the now popular ego-oriented and supportive psychotherapies. Weinberg (1956) suggested that a less formalistic approach to therapy be used--one that encourages the active role of the therapist. Goldfarb (1953) reported success with brief and wide-spaced sessions. Wolf (1971) has found that in the ego-supportive psychotherapy method patient and therapist oftentimes engage in discussions about religion. The patient's belief is not analyzed in terms of dependency needs. Illusions which give comfort to the elderly patient are not shattered in psychotherapy, but rather supported.

At the Philadelphia Geriatric Center we see clients whose ages range from approximately 60 to 95. They were referred to us by their physicians. The population we service includes outpatient community members and inpatient nursing home residents and hospital patients. A routine psychological assessment is administered to all newly referred patients before they are seen for treatment. From the psychometric data and behavioral observation the choice of therapist and mode of treatment are determined. While the presenting problems and diagnostic categories we see differ, the disorder that we most commonly deal with and that will be the focus of this talk, is depression-- both of a withdrawn and agitated nature.

Psychological trauma is often induced by (1) loss of loved ones, status, and beauty; (2) physical limitations in sight, hearing, and mobility; (3) fear of ill-health; and (4) fear of senility. Low self-esteem, uselessness, anger, feeling life is no longer worth living, and loneliness are common. Some of the depression is existential in nature. There are those that report a loss of both purpose and sense of identity. Others are involved in dealing, on a conscious level, with their nearness to death and are searching for an understanding and meaning for their lives. For some, there is a large somatic component along with the depression. This can indicate an unfulfilled need for attention or care.

Goldfarb (1967) aptly states the condition of the depressed older client. He says, "The depressed patient longs for assistance which has come to be equated with or supplanted by a desire for understanding, for evidences of regard and obligation regarded as 'love', nostalgically yearned for, and which, when gained or anticipated, evokes feelings of security, comfort and pleasurable success. The therapeutic relationship is the response to dependency strivings. It is the basic therapeutic tool to use with depressed elderly clients. The provision of a parental figure, a significant other, an ally, a confidant, and even a magician can be successfully achieved with the older patient. The illusion of the potent and caring therapist can oftentimes provide the gratification of emotional

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needs for punishment, affection, respect, and protection. When these needs are met in psychotherapy, they need not be acted out inappropriately in the home or hospital setting; new behaviors and goals can then be achieved. A visible diminution in anxiety is often noted because the "protective" parent has been found. For some, the therapist is the one human being the patient has available to relate to on an intimate personal level. The therapist may constitute the patient's only present object relationship and may in fact be the last relationship the patient ever forms.

How this relationship is set up is unique for every patient. From the psychometric data we've gathered on a patient, we have a sense of his or her needs, abilities, and emotional problems--the therapy is shaped, at least from the outset, from our original assessment data.

We begin with multiple weekly sessions. Once the relationship is established and progress visible, the number of sessions is reduced. The therapist must, especially with this age group, work to see that the patient does not perceive this as (1) rejection; or (2) a message that, "I need to be in bad shape to get protection, caring, loving, attention, whatever." Therefore, it is often useful to wait a few weeks to ensure stability of the new level of progress before discussing reduction of the frequency of sessions with the patient. When we do discuss this it is with a spirit of rejoicing--fewer sessions means growth, a movement up from depression. More attention is given to good insights and behavioral strides than to emotional upsets and somatic complaints. The message should never be that care and concern are given for sickness alone. Attention is not only achieved through verbal means. Physical touch is a clear indication to an older person that he or she is a viable human being. We often kiss our clients hello and good-bye or embrace them when they cry and are sad. The use of physical touch is not only highly reinforcing to the older person whose choice and scope of reinforcers is limited, but also helps foster the dependency relationship.

While not discounting patient's feelings of depression and anxiety, we stress the importance of activity level to overcome depression. The least bit of reported activity is supported. The method of support is tailored to the individual client. For some we rejoice loudly, for others a quiet smile is all that is needed. What can occur is that activity level increases, and a positive change in affect is noted by the therapist, even though reported depression remains consistent over sessions. We continue to acknowledge the depression. The therapists reiterates how happy it makes him/her feel that the client is active; and, how he/shall feels badly for the client that he/she still feels sad.

This approach continues to solidify the therapeutic relationship. The knowledge that the therapist is a person who really cares and is concerned is probably the most basic foundation from which therapy can build. From this point patients are usually ready to begin the next stage of therapy where they share some of their major anxieties and upsets--past and present.

As sessions are decreased and emotional function stabilized, support is given for the patient to merge with a significant person other than the therapist. This could be a nurse, spouse, or friend. Termination is handled individually. For some, who have no other interpersonal relationships or have suffered traumatic single or multiple losses, real termination is rarely established. Some clients are seen monthly; some bi-monthly; some nursing home residents are given a five minute hello, how are your, and embrace every few weeks; and, for others therapy is terminated and patients are invited to call upon the therapist if they feel the need or desire to do so.

Honesty is important. The therapy must address the patient's limitations, as well as strengths. The relationship exists on many levels. One I have not yet

mentioned is that of student-teacher. Patients can be given information about ways to improve memory and compensate for sensory impairment. A patient's anxiety can lessen from the information that his or her memory dysfuntion may be due to depression or part of the aging process, and does not mean that they are losing their mind.

Merloo (1955) suggests helping older patients rediscover hidden inner resources to conquer feelings of uselessness and boredom. This takes great creativity. Many patients are physically impaired. Activity through reading, writing, or hobbies which require good sight or manual dexterity may be impossible. Utilization of fantasy, insight, and life review can provide much stimulation. Tape recorded books for the blind, group discussions, and large print magazines are also quite useful.

Self-esteem is low in most depressed patients. For a patient who has a good degree of ego strength we are quick to point out self-deprecating remarks he or she makes during sessions. We explain that self-denegrating verbal and non-verbal messages are indications of not only the way they view themselves, but also the way in which those in their world relate to them. We suggest that by changing these behaviors they may help feelings of depression. We always point out a patient's assets and view his or her emotional maturity and work and life experiences with an air of respect. Once there is somewhat of an ongoing therapeutic relationship established, asking patients for advice oftentimes increases self-esteem. The therapist is someone important to them; and he/she is asking them for help and guidance.

Patients are encouraged to verbalize hostility once the relationship between therapist and patient is solidified. Patients resent being condescended to, pitied, and neglected as well as being left without purposeful goals. They are angry about physical and intellectual decline. Anger is expressed towards authority figures, therapists, family members, and the world.

The fact that the therapist is likely to be as much as sixty years younger than the patient has a definite impact on the transference (Hiatt, 1971). In addition, a patient over 60 has acquired many more significant others in his or her life than has the younger patient. Just the fact that a spouse and child may occupy a greater amount of time in the patient's life than his or her parents can alter the transference. Out of a group of 19 patients Hiatt (1971) reported 7 patients to form a parental transference, 6 patients a peer or sibling relationship, 4 patients a child or child-in-law transference, and 2 patients a sexual transference.

We do not work directly with the transference in terms of analyzing it. We allow it to develop and shift over time. We transact with patients on numerous levels, quite like one does in a close interpersonal relationship. The level of communication varies, the therapist is: (1) a providing parent to a needy child; (2) a teacher to a student; (3) an equal who shares in the joys and sorrows of life; (4) a child asking an adult authority for guidance and advice.

As many have pointed out (Goldfarb and Turner, 1953; Grotjahn, 1955; and Zinberg, 1964) the therapist must have a clear understanding of his or her relationship with his or her own parents and grandparents before treating other people's parents. Common countertransference reactions: (1) oversolicitousness; (2) idealization; (3) unrealistic expectations of strength; (4) subtle deprecations; (5) competitive feelings; and (6) pity--all of which can be seen as related to a therapist's own parents (Hiatt 1971). The therapist can feel that the older patient should be (1) obeyed, (2) feared, or (3) praised--based upon strong remnants from his or her childhood (Gitelson, 1948).

A therapist must examine sexual taboos he or she has towards older patients' sexual lives. As Grotjahn (1955) said, "The therapist who hopes the old person lives beyond sin and sex, like angels, is most likely not to understand one of their most important sources of conflicts, guilt, and depression." Countertransference reactions to the incidence of debilitating physical illness and death are a possibility. A common response of a therapist who treats the elderly is to use denial and insist that the patient be healthy (Hiatt, 1971). Peck (1966) has suggested that this may serve to counteract wishes for a patient's death and the therapist's guilt of surviving. It may also be a threat to one's own feeling of immortality.

Younger therapists may be manipulated to feel guilty about being younger. The therapist must be secure enough to withstand both a patient's hostility and his or her attempt to make the therapist feel guilty and/or incompetent due to the therapist's youth. You cannot do multi-level relationship therapy from a defensive position.

What I hope I have achieved is to highlight for you the importance of the therapeutic relationship when working with elderly depressed patients. Through his or her relationship with you the older person can work through feelings of low self-worth, uselessness, anger, loneliness, feeling life is no longer worth living. The therapeutic relationship model is exciting in its potential for interaction with patients on numerous levels. This naturally brings up numerous countertransference issues which are unique for the therapist who works with elderly clients. It is worth resolving those issues because working with elderly patients can be a rewarding and oftentimes successful venture.

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